

Patient Name: _____ DOB: _____

Patient's Phone: _____ Referring Physician: _____

Office Phone: _____ Diagnosis/Symptoms: _____

Insurance Carrier(s): _____

Dialysis Graft/Fistula Declot Problematic (not thrombosed) Fistula

Remove Dialysis Catheter Replace / Repair Problematic Dialysis Catheter

Hemodialysis Catheter ___ Acute ___ Chronic

Other: _____

Comments: _____

Is the patient on blood thinners? _____ Date Stopped: _____
Please note that blood thinners must be stopped several days prior to interventional procedures

Check if one applies: Coumadin _____ Heparin _____ Plavix _____ Other _____

PROVIDER SIGNATURE: _____ Date: _____

